STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IN005327	A. BUILDING: _____ B. WING _____	07/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FLOYD MEMORIAL HOME HEALTH CARE	1915 BONO RD NEW ALBANY, IN 47150

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments This was a home health state re-licensure survey. Survey dates: July 8 - July 14, 2014 Facility #: IN005327 Medicaid Vendor #: 100264230A Surveyor: Nina Koch, RN, Public Health Nurse Surveyor Unduplicated 12 month census: 1706 Records Reviewed: 20 Home visits: 10 Floyd Memorial Home Health Care was found to be in compliance with the Indiana rules for Home Health Agencies 410 IAC Article 17 Quality Review: Joyce Elder, MSN, BSN, RN July 17, 2014	N 000		